

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

113011

3024

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
50		f. STREET ADDRESS <b>606 E. Lombard</b>	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>AUGUSTA V. ASKIN</b>		First	Middle
4. DATE OF DEATH <b>March 2 1959</b>		Last	Month Day Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>1-1-87</b>		9. AGE (In years last birthday) <b>72 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Frank Askin</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah Bell</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW I</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease, severe</b>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO <b>420.0</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis generalized severe</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Operation: Sympathectomy right lumbar chain (2-27-59)</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>VA</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 23, 1959</b> , to <b>March 2, 1959</b> , <del>xxxxxxxxxxxxxx</del> and that death occurred at <b>3:20 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>S. P. Lacerva</i>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>		M.D. <b>V.A. Hospital, Perry Point, Md. 3-2-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>General</b>		22b. DATE THEREOF <b>3-4-59</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Funer Israel</b>
22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc. 2100-2 Eutaw Pl. Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>DAT MAR 4 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

1. Bright  
2. Dark  
3. Light

1. Bright  
2. Dark  
3. Light

1. Bright  
2. Dark  
3. Light

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03012

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

execute the certificate, writing the word "pendin'" in pencil in Item 18. Give log # 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

99

I

V.S. A15ME  
SM 2/57

0  
MATERIAL CERTIFICATION

2

B

3025

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural		c. LENGTH OF STAY IN lb 6 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital DOA				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter		First Middle		Last Barton		4. DATE OF DEATH March 15		Month Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 26, 1916		9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY State Road		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry Barton				14. MOTHER'S MAIDEN NAME Louisa Barton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tot. no. or unknown) no		16. SOCIAL SECURITY NO. 227-24-3232		17. INFORMANT Mrs Walter Barton North East, Rd, Md		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH 5 min			
4/20.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO							
(c)		DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>R.C. Dodson</i>		EXAMINER'S NAME (Type) R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED March 16, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 17, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Methodist		22d. LOCATION (City, town, or county) North East, Cecil Co., Md			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph P. Grant</i>		ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE MAR 17 '59		24b. REGISTRAR'S SIGNATURE <i>Charles S. Tracy</i>			

RECORDED - STATED TO BE A COPY OF THE ORIGINAL  
PRINTED IN 1803 BY WILLIAM JAMES.

STATE NO.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03013

Reg. Dist. No.

3026

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun (Rural)</b>		c. LENGTH OF STAY IN 1b <b>25 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rising Sun (Rural)</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Irvin</b>	Middle <b>Roscoe</b>	Last <b>Basham</b>	4. DATE OF DEATH	Month <b>March 20</b>	Day <b>1959</b>	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1901</b>	9. AGE (In years lost birthday) <b>57 yrs.</b>	IF UNDER 1 YEAR Months <b>57</b>	IF UNDER 24 HRS Hours <b>00</b>	Day Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Floyd, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert Hatcher Basham</b>				14. MOTHER'S MAIDEN NAME <b>Martha Ridinger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-36-0734</b>		INFORMANT <b>Mrs. Roscoe Basham</b>		Address <b>Rising Sun, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Due to</b> <b>(b)</b> <b>Due to</b> <b>(c)</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Refract's Rev. C. Brown - 5 yrs.</b> <b>Myocarditis &amp; hypofusion - 10 yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Baltimore, Md.</b>	(County)	(State)
21. I certify that I attended the deceased from <b>Mar. 2, 1959</b> , to <b>March 20, 1959</b> , that I last saw the deceased alive on <b>Mar. 6, 1959</b> , and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert Hatcher Basham</b>				ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b> DATE SIGNED <b>Mar. 24, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		22b. DATE THEREOF <b>3/23/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Brookview Cemetery</b>		22d. LOCATION (City, town, or county) <b>Rising Sun, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Carl Tyson - Rising Sun Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Mar 24 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

Final

Final

Final

(Final) and (Initial) - page 25

(Final) and (Initial)

RE

RE: Serial

Serial #

Serial #

Serial #

RE: 1601-00-000

RE: 1601-00-000

RE: Serial # 1601-00-000

RE:

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03014

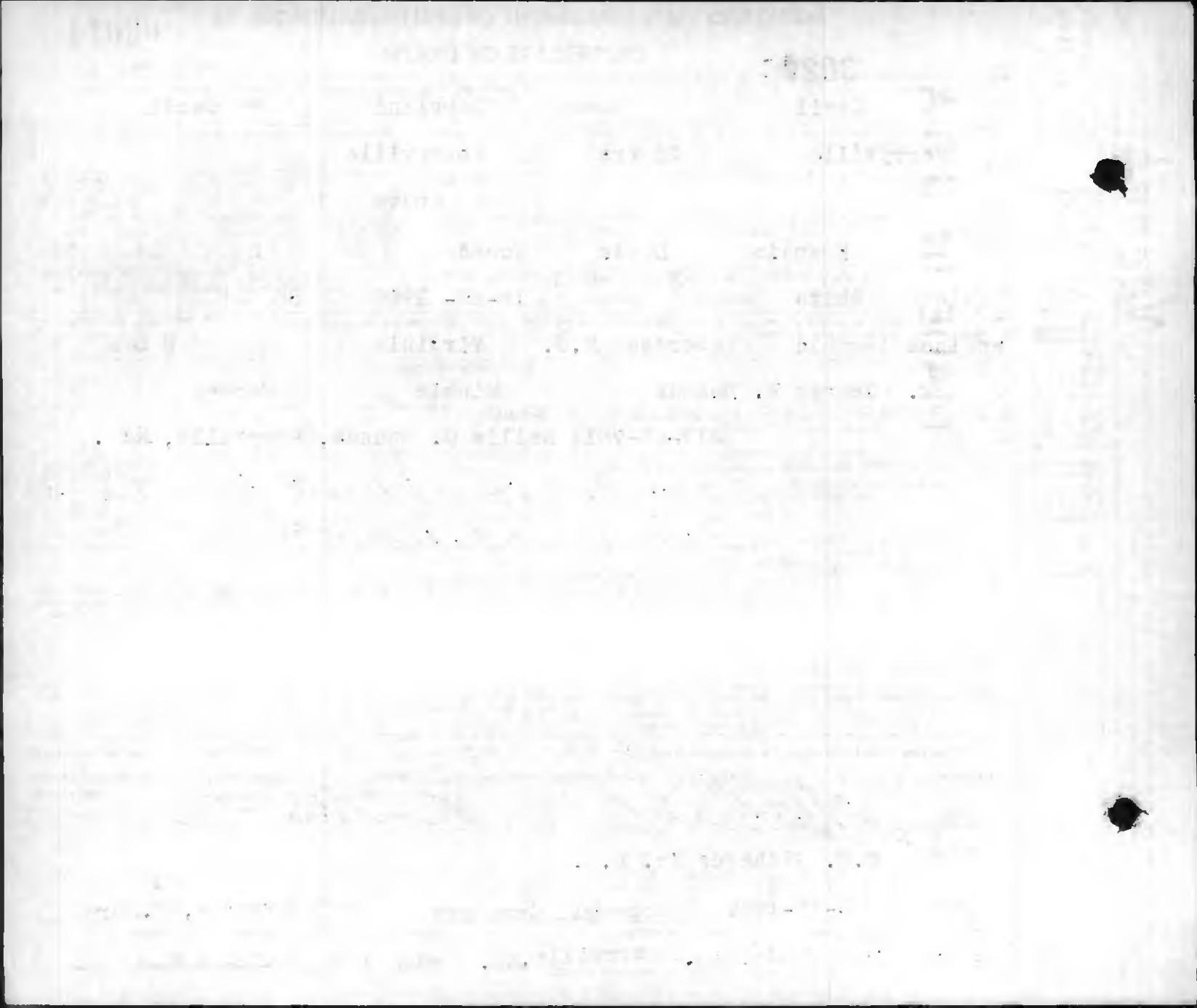
## CERTIFICATE OF DEATH

Reg. Dist. No.

3027

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page \_\_\_\_\_ may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by \_\_\_\_\_, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>		c. LENGTH OF STAY IN TB <b>35 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>	
3. NAME OF DECEASED (Type or print) <b>Francis Davis</b>		d. STREET ADDRESS <b>Route 7</b>	
First <b>Francis</b>		Middle <b>Davis</b>	Last <b>Bounds</b>
4. DATE OF DEATH <b>3 14 1959</b>		Month <b>3</b>	Day <b>14</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>12-29- 1900</b>		9. AGE (In years last birthday) <b>58 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineering Aid</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aberdeen P.G.</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Rev. George W. Bounds</b>	
14. MOTHER'S MAIDEN NAME <b>Minnie Harvey</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>217-07-7811</b>		17. INFORMANT <b>Nellie G. Bounds, Perryville, Md.</b>	18. ADDRESS
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer Mediastinum &amp; metastasis to Brain</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Months</b>	
164 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Hypertension. Card. Vascul. Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
(c)		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-22</b> , 19 <b>51</b> , to <b>3-14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3-14</b> , 19 <b>59</b> , and that death occurred at <b>7:54 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. <b>Port Deposit, Md.</b> DATE SIGNED <b>3-14-59</b>	
ACTUAL SIGNATURE <b>G.H. Richards Jr. M.D.</b>		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-17-1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Hopewell Cemetery</b>
22d. LOCATION (City, town, or county) <b>Port Deposit, Md. Rural</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leva Patterson Jones, Perryville, Md.</b>		24a. ADDRESS <b>Perryville, Md.</b>	24b. REC'D BY REGISTRAR DATE <b>MAR 17 '59</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03015

3028

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Cecilton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>HENRIETTA</b>	Middle	Last <b>BROWN</b>	4. DATE OF DEATH <b>October, 4, 1870</b>	Month <b>March</b> Day <b>12,</b> Year <b>19 59</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>October, 4, 1870</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Dofs <b>0</b> Hours <b>0</b> Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Patrick Anderson</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Registrar</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
		<b>None</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		<b>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
		<b>Cerebral Arteriosclerosis</b>		years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Far advanced Senility &amp; generalized arteriosclerosis.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p.m.	Month <b>Mar.</b>	Day <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cecilton, Md.</b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Mar. 1, 1959</b> to <b>12 Mar, 1959</b> , that I last saw the deceased alive on <b>12 Mar, 1959</b> , and that death occurred at <b>11 30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cecilton, Md.</b> DATE SIGNED <b>16 Mar 59</b>					
ACTUAL SIGNATURE <b>Wallace Feinstein</b>		M.D.			
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March, 15, 1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Cecilton Cem.</b>	22d. LOCATION (City, town, or county) <b>Cecilton, Cecil Co.</b> (State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>		ADDRESS <b>Wellington Rd.</b>	24a. REC'D BY REGISTRAR DATE <b>MAR 18 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

87-30257-17-Sub 10-Block 1-Sub STATE 0004780

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03016

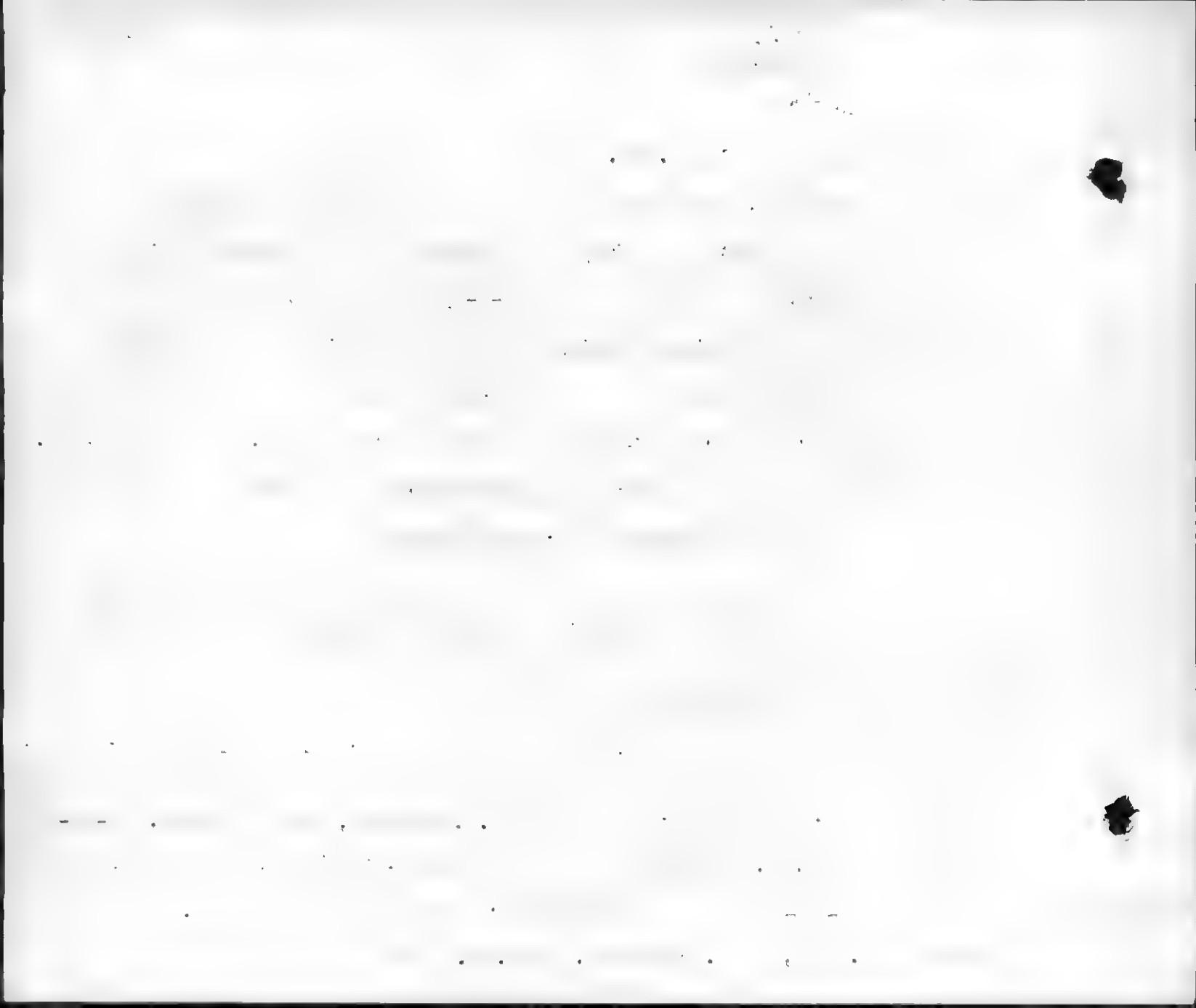
3029

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>21 yrs. 7 mo. 11 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>WILLIAM</b>	Middle <b>(NMI)</b>	Last <b>BURTON</b>
4. DATE OF DEATH <b>March 11</b>	Month <b>March</b>	Day <b>11</b>	Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-8-95</b>
9. AGE (In years last birthday) <b>64</b>	10. IF UNDER 1 YEAR Months <b>6</b>	11. IF UNDER 24 HRS Days <b>4</b>	12. IF UNDER 24 HRS Hours <b>15</b>
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butler</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>	11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Ernest Burton</b>	14. MOTHER'S MAIDEN NAME <b>Carrie Shaw</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>WW I</b>	INFORMANT <b>Not obtainable Hospital Records, VAH, Perry Point, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease, severe</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Fibrosis of the myocardium</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Arteriosclerosis generalized, severe</b>	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that attended the deceased from <b>July 28</b> , 19 <b>37</b> , to <b>March 11</b> , 19 <b>59</b> <del>xxxxxx</del> and that death occurred at <b>8:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>S. P. LACERVA</b> M.D. <b>V.A. Hospital, Perry Point, Md. 3-12-59</b>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
S. P. LACERVA		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-16-59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hensley Fun. Home, 578 W. Biddle St. Balto. Md.</b>	ADDRESS	24a. REC'D BY REGISTRAR <b>MAR 16 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the physician or attending physician or FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02943

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 4 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

The bottom copy may be retained by the hospital or attending physician.

VS AISC 1-55-10W

3030

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Cecil North East	MARYLAND LENGTH OF STAY (in this place) Life	STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pratt Nursing Home		X North East	
<b>3. NAME OF DECEASED (Type or Print)</b> CORA BURNS CAMERON		<b>4. DATE OF DEATH</b> Mar 30 1959	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct 28, 1885
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY at Home	9. AGE last birthday 73 yrs.
13. FATHER'S NAME Jonathan P. Burns		14. MOTHER'S MAIDEN NAME Margaret Terry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS Murray H. Cameron
<b>18. MEDICAL CERTIFICATION</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>I. IMMEDIATE CAUSE (A) CARDIOVASCULAR FAILURE</p> <p>ANTECEDENT CAUSE(S) DUE TO (B) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE YEARS</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST, DUE TO (C) GENERALIZED ARTERIOSCLEROSIS YEARS</p> <p>GLAUCOMA (BILATERAL) PROGRESSIVE HYPERTROPHIC ARTHRITIS DEFORMANS YEARS</p>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5-23-1958, to 3-30-1959, that I last saw the deceased alive on 3-30-1959, and that death occurred at 5:15 P.M., from the causes and on the date stated above.			
SIGNATURE <i>John L. Burns</i>		ADDRESS (Street, city, town, state) DATE SIGNED NORTH EAST, Md. 3-30-59	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/2/59	NAME OF CEMETERY OR CREMATORIUM North East Cemetery
24. REC'D BY REGISTRAR APR 7 '59		REGISTRAR'S SIGNATURE <i>John S. Kraus</i>	LOCATION (City, town, or county) (State) North East, Md.
25. FUNERAL DIRECTOR'S SIGNATURE Grant Funeral Home		ADDRESS North East, Md.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03017

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Fill in Item 3 should be filled as a burial-transit permit. File pages 1 and 2 with the Little Local Health, or its designated agent, prior to burial, cremation, or removal, and return event within 72 hours after death.

3031		Reg. Dist. No.													
1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Pa. b. COUNTY <b>Chester</b>		e. IS REL. DENE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nottingham R.D.</b>		c. LENGTH OF STAY IN lb <b>5 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxford</b>		d. STREET ADDRESS									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Graybeal Nursing Home</b>															
3. NAME OF DECEASED (Type or print) <b>Anna</b>		First <b>Belle</b>	Middle <b>Clark</b>	Last	4. DATE OF DEATH <b>3 4 1959</b>	Month <b>3</b>	Doy <b>4</b>	Year <b>1959</b>							
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-18-1873</b>		9. AGE (In years last birthday) <b>85</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Chester Co. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>James A. Criswell</b>								14. MOTHER'S MAIDEN NAME <b>Gaoline Bailey</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>James O. Clark, North East. Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b>															
DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arterio sclerosis</b>															
DUE TO (c)															
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>R.C. Dodson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3-5-59</b>											
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		22b. DATE THEREOF <b>3/1/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Fago Manor</b>		22d. LOCATION (City, town, or county) <b>Londonderry Township, Chester</b>		(State)							
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22e. ADDRESS		24a. REC'D BY REGISTRAR <b>MAR 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>									
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph M. Reed, Rising Sun, Md.</b>															



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03018

3017

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 509 North Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Harry	Middle L.	Last Croak
4. DATE OF DEATH March	Month 7	Day 19	Year 59
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1889
9. AGE (In years lost birthday) 69 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elkton Supply Co.	10b. KIND OF BUSINESS OR INDUSTRY Building Material	11. BIRTHPLACE (State or foreign country) Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Croak	14. MOTHER'S MAIDEN NAME Ellen Glass		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO 213-05-6164	17. INFORMANT Mrs. Dora N. Croak, Elkton, Md.	509 North St.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Arteriosclerosis, cerebral (c)		INTERVAL BETWEEN ONSET AND DEATH March	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1957, to March 7, 1959, that I last saw the deceased alive on <u>March 7</u> , 1959, and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Elkton, Md.</u>			
ACTUAL SIGNATURE <u>Dr. H. Precher</u>	DATE SIGNED <u>March 9 1959</u>		
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/10/59	22c. NAME OF CEMETERY OR CREMATORIUM Gilpin Manor Memorial Park, Elkton, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>	ADDRESS Elkton, Md.	24a. REC'D BY REGISTRAR DATE MAR 12 '59	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03019

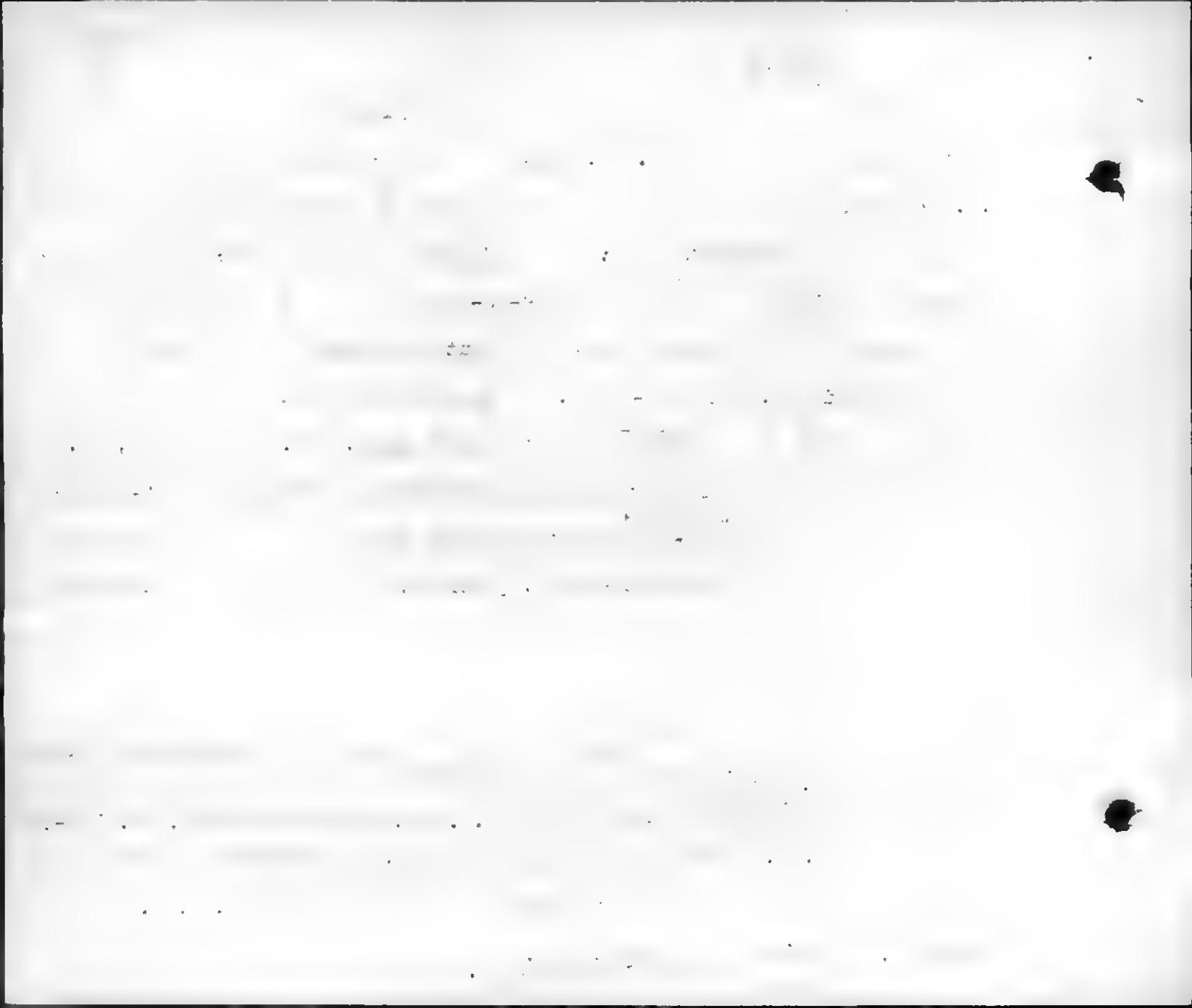
3032

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please leave carbon papers. Pages 1 and 2 must be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN lb <b>9yrs. 8mo. 14days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>V.A. Hospital</b>				d. STREET ADDRESS <b>429 Hamilton Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>EVERETTE</b>	Middle <b>HUBERT</b>	Last <b>CROXTON</b>	4. DATE OF DEATH Month <b>March</b>	Day <b>9</b>	Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>4-26-1896</b>	9. AGE (In years last birthday) <b>62 yrs</b>	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS Days <b>2</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Realtor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William L. Croxton - (Dec.)</b>		14. MOTHER'S MAIDEN NAME <b>Mary Cauthen (Dec.)</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW I 577-03-3601</b>	INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>unresolved</b>		<b>Bronchopneumonia right lower &amp; middle lobes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) <b>Arteriosclerotic heart disease</b>				unknown			
(c) <b>Arteriosclerosis, generalized</b>				unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 23, 1949</b> , to <b>March 9, 1959</b> , and that death occurred at <b>7:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>SR Lacerva M.D. V.A. Hospital, Perry Point, Md. 3-9-59</b>							
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>							
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/11/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Lacerva INC.</b>		ADDRESS <b>8434 Georgia Ave. Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



03020

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3035		Reg. Dist. No.															
1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <b>Del.</b> b. COUNTY <b>New Castle</b>															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton, Md.</b>		c. LENGTH OF STAY IN 1b <b>Visiting</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark</b>													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>349 E. Main</b>															
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <b>George E.C.</b>		First <b>George</b>		Middle <b>E.C.</b>		Last <b>Davis</b>		4. DATE OF DEATH <b>3 3 1959</b>		Month Day Year							
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-8-1885</b>		9. AGE (In years from birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting houses</b>		11. BIRTHPLACE (State or foreign country) <b>Goldsborough, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>William T. Davis</b>		14. MOTHER'S MAIDEN NAME <b>Sullivan</b>		Address Newark, De 1. <b>Mrs. George E.C. Davis. 349 E. Main St.</b>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH											
yes: <b>W.W.I.</b>				<b>Mrs. George E.C. Davis. 349 E. Main St.</b>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombus</b>																	
420.1 DUE TO																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis</b>																	
DUE TO (c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>R.C. Dedson</i>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3-4-59</b>											
EXAMINER'S NAME (Type) <b>R.C. Dedson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 6, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>White Clay Creek</b>		22d. LOCATION (City, town, or county) <b>Newark, Delaware</b>		(State)									
23. FUNERAL DIRECTOR'S SIGNATURE <i>G.T. Jones</i>		ADDRESS <i>Newark, Del.</i>		24a. REC'D BY REGISTRAR <b>MAR 10 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>											



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03021

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained by your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1, 2, and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Ced1		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural		c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East Rural		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William Robert Davis		First	Middle	Lost	4. DATE OF DEATH 1881	Month 3	Day 3	Year 1959
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 19, 1881	9. AGE (in years from birthday) 77 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector Ret	11. BIRTHPLACE (State or foreign country) North Carolina	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Marion Davis				14. MOTHER'S MAIDEN NAME Nan Baker		Address Robert Ray Davis North East, Md		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>R.C. Dodson</i>		EXAMINER'S NAME (Type) R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED March 4th, 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3-4- 1959		22c. NAME OF CEMETERY OR CREMATORIUM Glenwood		22d. LOCATION (City, town, or county) Bristol, Sullivan Co., Tenn (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Giam</i>		ADDRESS North East, Md		24a. REC'D BY REGISTRAR MAR 5 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thrall</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03022

3018

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Galena</b>		d. STREET ADDRESS <b>14 S</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>NELLIE</b>	Middle <b>P.</b>	Last <b>DEMPSEY</b>	4. DATE OF DEATH <b>March 2, 1959</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>October, 24, 1902</b>	9. AGE (In years (not birthday) yrs.) <b>56</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Galena, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry S. Dempsey</b>		14. MOTHER'S MAIDEN NAME <b>Winnie Walls</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>215-20-0888</b>		17. INFORMANT <b>Mr. Harry S. Dempsey,</b>		Address <b>Galena, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma totis</b>						INTERVAL BETWEEN ONSET AND DEATH	
1/18 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Carcinoma Nt + heart							
(c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACC-DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Feb 18, 1959</b> , to <b>March 2, 1959</b> that I last saw the deceased alive on <b>March 3, 1959</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Union Hospital, Elkton, Md.</b>		DATE SIGNED <b>3-1-59</b>	
ACTUAL SIGNATURE <b>E. Glauco Miresca, M.D.</b>							
PHYSICIAN'S NAME (Type) <b>Glauco Miresca, M.D.</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 5, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Galena Cemetery</b>		22d. LOCATION (City, town, or county) <b>Galena, Kent Co.</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ed. Dillman</b>		ADDRESS <b>Wellington, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Craig L. Evans</b>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 will be filed with the funeral director.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Page 1 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
Item 21 File 241 4-8-59 et  
**CERTIFICATE OF DEATH**

04217  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Ecc 1		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN TB Union		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton (Rural) RD #3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Rebecca	Middle Lynn	Last Dougherty	4. DATE OF DEATH	Month March	Day 17	Year 1959					
5. SEX	6. COLOR OR RACE Female	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1959	9. AGE (In years last birthday) yrs. Months 6	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS Days 6	Hours 50	Min 50				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Howard Dougherty				14. MOTHER'S MAIDEN NAME George Lewis								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT					Address Howard Dougherty, Elkton, Md. R.D.#3			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 769.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)		Premature Infant (wt: 1 lb. 14 oz.) - Premature delivery - mother with measles and pyrexia					INTERVAL BETWEEN ONSET AND DEATH 7 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I attended the deceased from <u>17 March</u> , 1959, to <u>17 March</u> , 1959, that I last saw the deceased alive on <u>17 March</u> , 1959, and that death occurred at <u>10:55 AM</u> , from the causes and on the date stated above.												
ACTUAL SIGNATURE <u>Klaus H. Huchler</u>		M.D.		P.O. ADDRESS (Street, city or town, state) <u>North East, Md.</u>		DATE SIGNED <u>18 March 1959</u>						
PHYSICIAN'S NAME (Type) <u>Klaus H. Huchler Jr. D.V.</u>												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/10/59		22c. NAME OF CEMETERY OR CREMATORIUM North East Methodist Cemetery		22d. LOCATION (City, town, or county) North East		(State) Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph P. Grant</u>		ADDRESS 17th Street, Jr. 1 no.				24a. REC'D BY REGISTRAR DATE MAR 20 '59		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

113023

3035

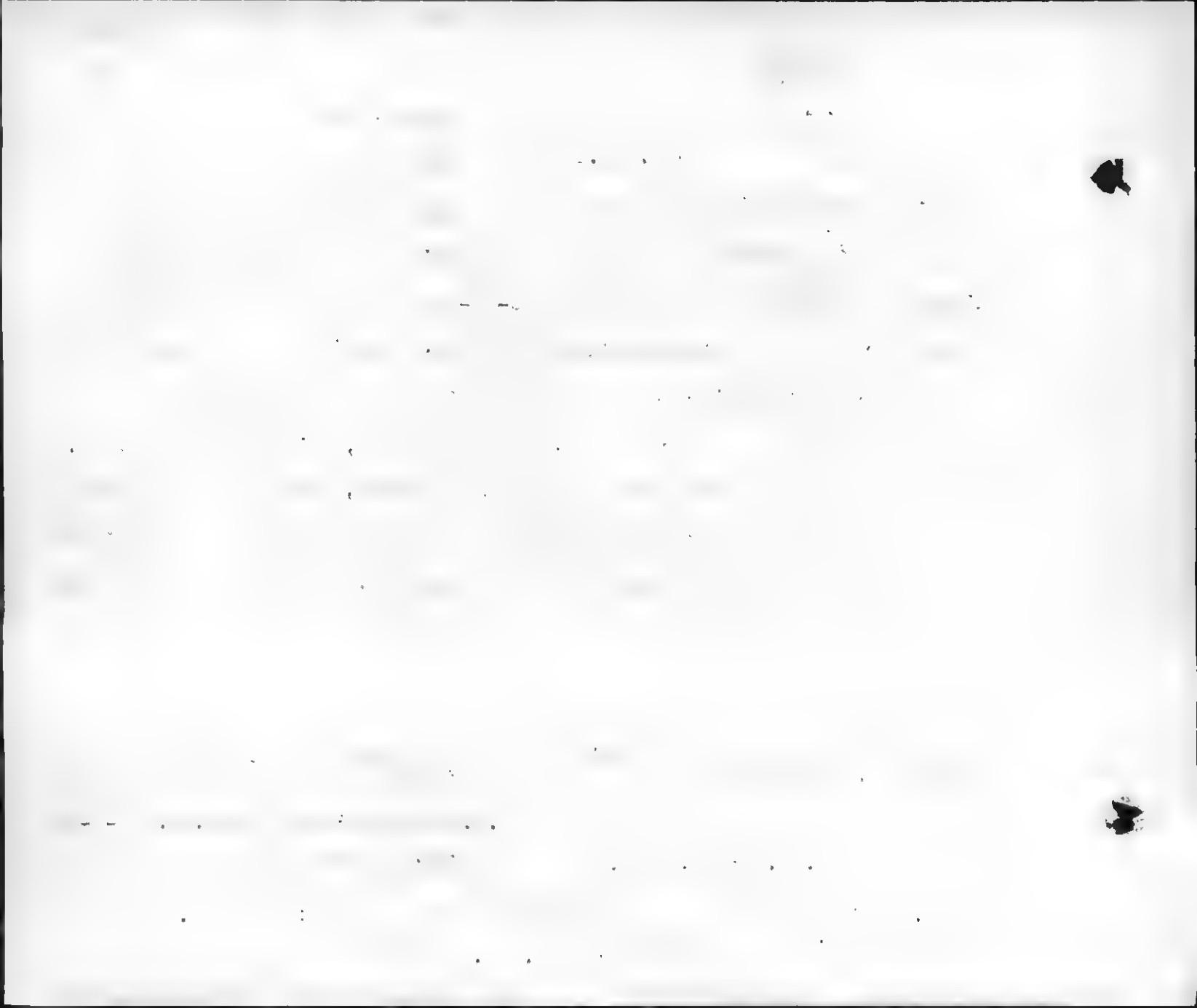
## CERTIFICATE OF DEATH

Reg. Dist. No. 96

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Pennsylvania</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN lb <b>32 yrs. 5 mo. 15 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print)	First <b>NESTER</b>	Middle <b>(NMI)</b>	Last <b>GARIN</b>
4. DATE DEATH	Month <b>March</b>	Day <b>28</b>	Year <b>19 59</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-15-88</b>
9. AGE (in years last birthday) <b>70 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Not obtainable</b>	
11. BIRTHPLACE (State or foreign country) <b>Central America</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Not obtainable from records</b>		14. MOTHER'S MAIDEN NAME <b>Not obtainable from records</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease, severe</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost (b) <b>Myocardial fibrosis</b>			
DUE TO (c) <b>Arteriosclerosis, generalized, severe</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 13, 19 26</b> , to <b>March 28, 19 59</b> and that death occurred at <b>8:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. L. Garey</i>		ADDRESS (Street, city or town, state) M.D. <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>4-1-59</b>	
PHYSICIAN'S NAME (Type) <b>J. L. GAREY, M. D.</b>		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>4/21/1959</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington &amp; Son</i>		24a. REC'D BY REGISTRAR DATE <b>APR 3 '59</b>	
ADDRESS <b>Havre de Grace, Md.</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03024			
CERTIFICATE OF DEATH										Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colora Md. Rural</b> c. LENGTH OF STAY IN lb <b>48 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Md.</b> b. COJN <b>Cecil</b> c. CITY (If outside corporate limits, write RURAL and give nearest town) <b>X Colora Md. Rural</b> d. STREET ADDRESS								
3. NAME OF DECEASED (Type or print) <b>Olive</b>					First	Middle	Last	4. DATE OF DEATH <b>March</b>		Month	Day	Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 1, 1885</b>		9. AGE (In years birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			11. BIRTHPLACE (State or foreign country) <b>Fenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Alexahder Russell</b>					14. MOTHER'S MAIDEN NAME <b>Amilia Jane Harding</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO <b>220-24-1207</b>		17. INFORMANT <b>Edward L.Gibson</b>		Address <b>Colora Md. Rural</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>153.8</b> <i>Carcinoma of Colon</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause last. (b) <i>Carcinoma of Spine - Metastatic</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>M.D. Washington 3rd</b>		20f. (City or town) <b>(County)</b> <b>(State)</b>				
21. I certify that I attended the deceased from <b>April 10</b> , 19 <b>58</b> , to <b>March 25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>March 21</b> , 19 <b>59</b> , and that death occurred at <b>M.D. Washington 3rd</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Dudley Phillips</b> PHYSICIAN'S NAME (Type) <b>Dudley Phillips, M.D.</b>										ADDRESS (Street, city or town, state) <b>DATE SIGNED</b> <b>3/26/59</b>			
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial 3-28-1959</b>					22b. DATE THEREOF <b>3-28-1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Hopewell Cem.</b>		22d. LOCATION (City, town, or county) <b>Port Deposit</b>		(State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jernome M. Mallon</b>					ADDRESS <b>Rising Sun Md.</b>		24a. REC'D BY REGISTRAR <b>DAMAR 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Koenig</b>				



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**CERTIFICATE OF DEATH**

Reg. Dist. No. 113025

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Cecil</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Jervis</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>rural - Conowingo</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>R.10</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Edward W. Greer</i>		First	Middle	Last	4. DATE OF DEATH <i>Mar. 27</i>	Month	Day	Year <i>1957</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 4, 1901</i>	9. AGE (In years lost birthday) <i>58</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ship fitter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ship building</i>		11. BIRTHPLACE (State or foreign country) <i>Toliver N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Wilborn Greer</i>		14. MOTHER'S MAIDEN NAME <i>Mary Louise Brather</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>233-10-5080</i>		17. INFORMANT <i>Ella Mobine Greer - Conowingo Maryland</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO <i>Acute Gastric Heart Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr. 45 min.</i>				
DUE TO <i>Anemia &amp; Rheumatic heart disease</i>		(c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		2-3 yr.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Conowingo, Cecil Co., Maryland</i>		20f. (City or town) <i>Darlington Md</i>		(County) <i>Darlington</i> (State) <i>Md</i>
21. I certify that I attended the deceased from <i>Mar. 3</i> , 19 <i>57</i> , to <i>Mar. 27</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Mar. 3</i> , 19 <i>57</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above						ADDRESS (Street, city or town, state) <i>Darlington, Md</i>		DATE SIGNED <i>3/28/57</i>
ACTUAL SIGNATURE <i>Dudley Phillips</i>		M.D.						
MATERIALS NAME (Type) <i>Dudley Phillips</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar. 31 1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Conowingo Byp. Cem.</i>		22d. LOCATION (City, town, or county) <i>Conowingo, Cecil Co., Maryland</i>		(State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M. Reed, Rising Sun, Md</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <i>Collected</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

113026

## CERTIFICATE OF DEATH

3038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u>		b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton R.D. 3</u>		c. LENGTH OF STAY IN 1b <u>20 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Elkton, R.D. 3</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Bettie</u>	Middle <u>Lawrence</u>	Last <u>Harris</u>	4. DATE OF DEATH	Month <u>March</u>	Day <u>16</u>	Year <u>19 59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1883</u>	9. AGE (In years lost birthday) <u>75 yrs</u>	IF UNDER 1 YEAR Months <u>0</u>	IF UNDER 24 HRS Days <u>0</u>	Hours <u>0</u>	Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>L.D. Lawrence</u>				14. MOTHER'S MAIDEN NAME <u>Tennie Lawrence</u>				Address <u>Mrs. Frank A. Stanley, Elkton, Md.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>-----</u>		17. INFORMANT <u>Mrs. Frank A. Stanley, Elkton, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Paroxysm of Colon</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>				20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) <u>None</u>		(County) <u>None</u>	(State) <u>None</u>
21. I certify that I attended the deceased from <u>2-1-</u> , 19 <u>59</u> , to <u>3-16-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-14</u> , 19 <u>59</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Jacob J. Greenwald</u> PHYSICIAN'S NAME (Type) <u>Jacob J. Greenwald</u>				ADDRESS (Street, city or town, state) <u>202 E 17TH ST ELKTON MD</u>				DATE SIGNED <u>3/17/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/59</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Gilpin Manor Memorial Park, Elkton, Md.</u>		22d. LOCATION (City, town, or county) <u>Elkton, Md.</u>		(State) <u>None</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Nicks</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



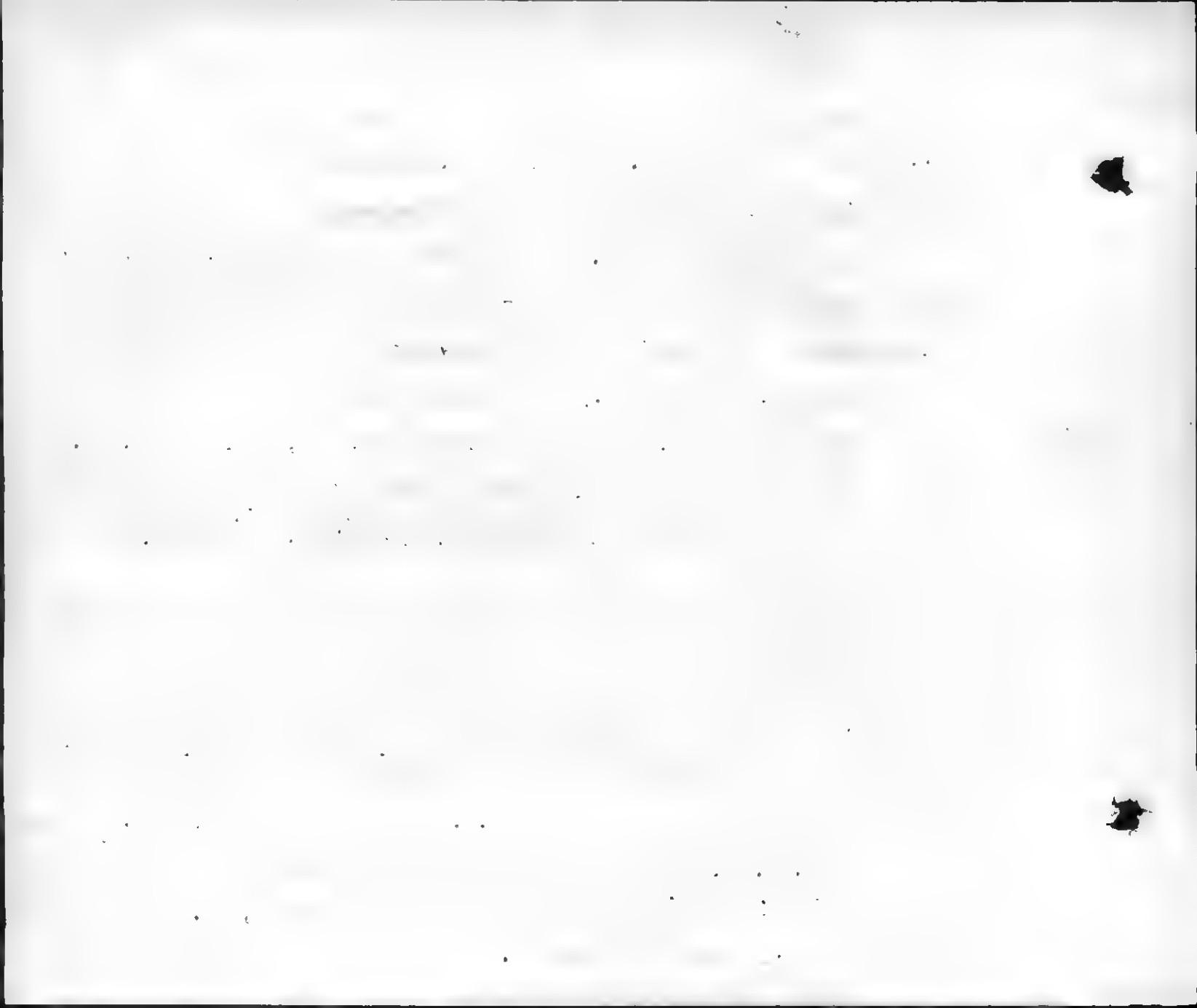
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 Item 16 File # 3039 Date 3-31-59 et  
 3039 **CERTIFICATE OF DEATH**

Reg. Dist. No. 96

113027

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN IB <b>4 mo. 27 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LEOLIA</b>		First <b>C.</b>	Middle <b>HART</b>
4. DATE OF DEATH <b>March 25 1959</b>		Last	Month
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <b>8-4-1910</b>		9. AGE (In years last birthday) <b>48 yrs</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Receptionist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thornton S. Cooper (dec.)</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor Hansel</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>218-38-0791</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis, adenocarcinoma of the right breast with metastases to the pleura, hilar lymph nodes, peritoneum, preaortic nodes and skin</b> DUE TO <b>unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>unknown</b> DUE TO (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that attended the deceased from <b>October 26, 1958</b> , to <b>March 25, 1959</b> and that death occurred at <b>8:27 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>J. L. Garey</i>		DATE SIGNED <b>3-26-59</b>	
PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b>		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>3/26/59</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Unknown</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington &amp; Son, Havre de Grace, Md.</i>		24a. REC'D BY REGISTRAR DATE <b>MAR 31 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3040

## CERTIFICATE OF DEATH

103028

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE  Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN lb 40 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Randalia Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City	
f. STREET ADDRESS Randalia Rd.		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)  ALEXANDER		4. DATE OF DEATH March 8, 1959	
First Middle Last		Month Day Year	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 10/15/1887	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years legal birthday) yrs. 100		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt.		10b. KIND OF BUSINESS OR INDUSTRY C & D Canal	
11. BIRTHPLACE (State or foreign country) Ukraine		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Hotra		14. MOTHER'S MAIDEN NAME Florence	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT 214-12-2155A Mrs. Alexander Hotra Address Ches. City	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 424.1 DUE TO Mycocystitis		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Total Passenger, left leg following sprain effects - jaw		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1955, to March 8, 1959, that I last saw the deceased alive on March 7, 1959, and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Davis MD		ADDRESS (Street, city or town, state) Chesapeake City, Maryland	
PHYSICIAN'S NAME (Type) Henry V. Davis MD		DATE SIGNED 3/6/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/10/1959	
22c. NAME OF CEMETERY OR CREMATORIUM St. Roses Cemetery		22d. LOCATION (City, town, or county) Ches. City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pip in Funeral Home		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR Arthur S. Turner		24b. REGISTRAR'S SIGNATURE	
DATE MAR 12 '59			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician signed by the attending physician and completely filled in before funeral director. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in before funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**CERTIFICATE OF DEATH**

Reg. Dist. No. 03029

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake City</b>		c. LENGTH OF STAY IN 1b <b>43 Yrs.</b>		a. STATE <b>Md.</b>	b. COUNTY <b>Cecil</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chesapeake City</b>		
				d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print)		First <b>JOHN</b>	Middle <b>HRABEC</b>	4. DATE OF DEATH <b>March 16, 1959</b>	Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 18, 1886</b>	9. AGE (In years last birthday) <b>73 yrs.</b>	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Ukraine</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>No Info</b>		14. MOTHER'S MAIDEN NAME <b>No Info</b>		Address <b>Chesapeake City, Md.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Michael Hrabec</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>154X</b>		DUE TO <b>CARCINOMA OF RECTUM</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 15, 1959</b> to <b>March 16, 1959</b> , that I last saw the deceased alive on <b>March 15, 1959</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>3/16/59</b>
ACTUAL SIGNATURE <b>Henry V. Davis</b>		M.D.				
PHYSICIAN'S NAME (Type) <b>Henry V. Davis</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 18, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Roses Cemetery</b>		22d. LOCATION (City, town, or county) <b>Chesapeake City, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIE FUNERAL HOME</b>		ADDRESS <b>Elkton, Md.</b>		24a. REC'D BY REGISTRAR <b>DONALD M. GEE</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>
				DATE <b>MAR 24 '59</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03030

3042

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit, Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Craig Town</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Mary</b>	Middle <b>Louise</b>	Last <b>Jackson</b>
4. DATE OF DEATH	Month <b>March</b>	Day <b>13</b>	Year <b>19 59</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 5, 1882</b>
9. AGE (In years last birthday) <b>77 yrs</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>	11. KIND OF BUSINESS OR INDUSTRY <b>11. BIRTHPLACE (State or foreign country) <b>Maryland</b></b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Samuel</b>	14. MOTHER'S MAIDEN NAME <b>Jackson</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO <b>None</b>
17. INFORMANT <b>Ray Jackson, Port Deposit, Md.R.F.D.</b>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>592 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>One day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cardio - Vasculor Failure</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>02-7-1958</b> to <b>March 12, 1959</b> that I last saw the deceased alive on <b>March 12, 1959</b> , and that death occurred at <b>9A</b> M, from the causes and on the date stated above ACTUAL SIGNATURE <b>Clarence I. Benson, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-16-1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Asbury Cemetery</b>
22d. LOCATION (City, town, or county) <b>Port Deposit, Md. Rural</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur J. Green &amp; Sons</b>		24a. REC'D BY REGISTRAR <b>DAT MAR 16 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
 1SM 9/58



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03031

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural		c. LENGTH OF STAY IN lb 32 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, Rural				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Frances	Middle Galatian	Last Janney	4. DATE OF DEATH 3	Month 4	Day 19	Year 59
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4-3-1873	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 6		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Andrew Bedford Galatian			14. MOTHER'S MAIDEN NAME Mary James					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT John R. Janney Jr North E st Rd Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO  443X DUE TO Hypertension Anterior occlu- sive		INTERVAL BETWEEN ONSET AND DEATH 10 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) North East		(County) (State)
21. I certify that I attended the deceased from <u>3-4-57</u> , 19 <u>57</u> , to <u>3-4-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-4-57</u> , 19 <u>57</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>William J. Miller</u>		ADDRESS (Street, city or town, state) <u>North East, MD</u>		DATE SIGNED <u>March 4, 1957</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-59		22c. NAME OF CEMETERY OR CREMATORIUM Bay View Methodist		22d. LOCATION (City, town, or county) Bay View, Cecil Co., Md (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>		ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR MAR 9 '59		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3020 CERTIFICATE OF DEATH

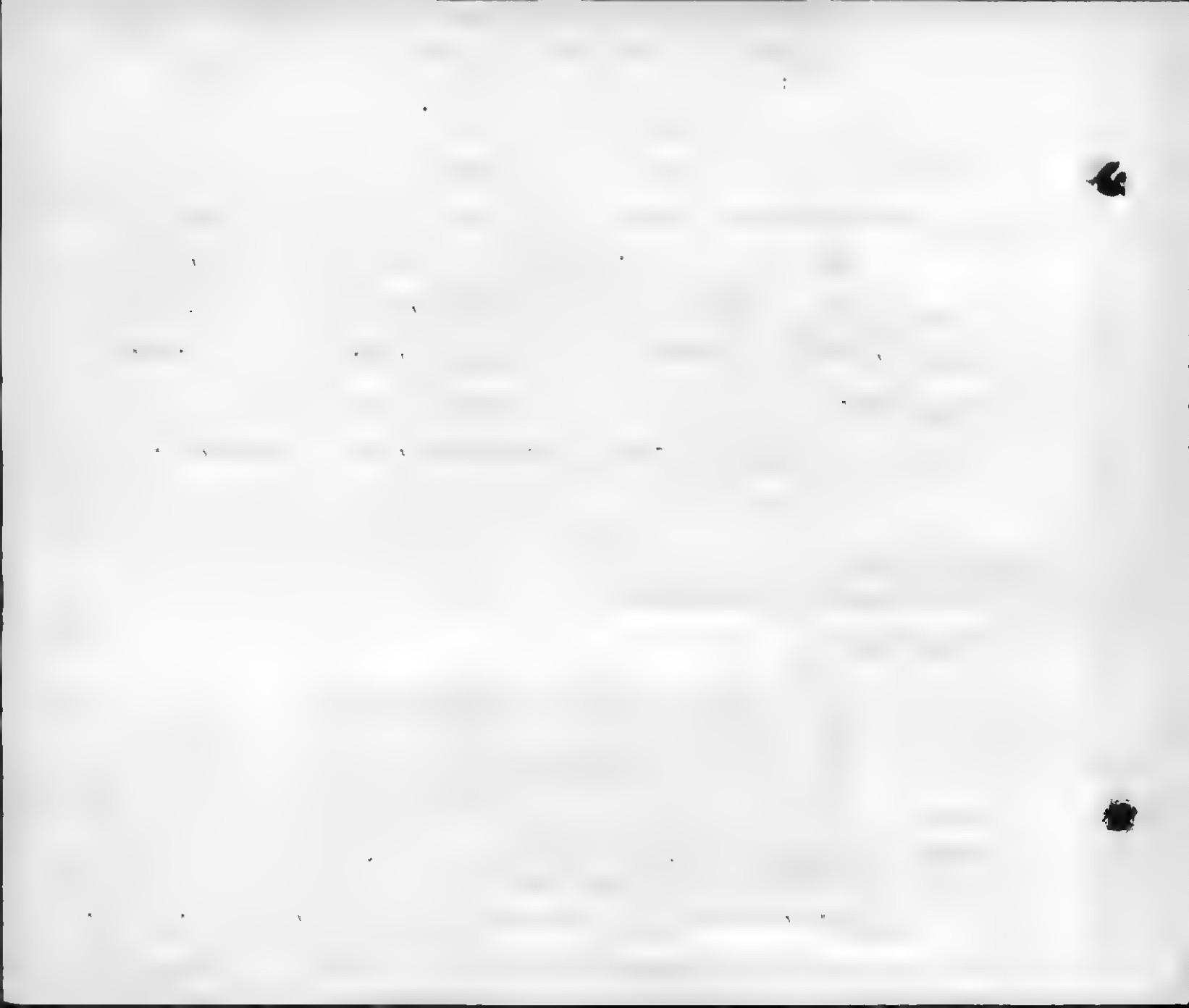
03032

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Md.</b>		b. COUNTY <b>Cecil</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Cecilton</b>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>ERNEST</b>	Middle <b>J.</b>	Last <b>MANN</b>	4. DATE OF DEATH	Month <b>March 10,</b>	Day	Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>October 14, 1880</b>	9. AGE (In years lost birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter, General</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>George Mann.</b>		14. MOTHER'S MAIDEN NAME <b>Ludorna Grimes</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>221-03-3885</b>		17. INFORMANT <b>Mrs. Alice Mann,</b>		Address <b>Cecilton, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b>		DUE TO <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hours.</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) <b>Arteriosclerotic Heart Disease.</b>		years				
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Shock due to fall down stairs; Pneumonia</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. p.m.	Month <b>Mar.</b>	Day <b>19</b>	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cecilton, Md.</b>	20f. (City or town) <b>Cecilton</b>	(County) <b>Cecilton</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>2 Mar.</b> , 19 <b>59</b> , to <b>10 Mar.</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10 Mar.</b> , 19 <b>59</b> , and that death occurred at <b>5a</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Wallace Obenshain</b> M.D. ADDRESS (Street, city or town/state) <b>Cecilton, Md.</b> DATE SIGNED <b>11 Mar 59</b> PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b> Cecilton, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 13, 1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Cecilton Cemetery</b>	22d. LOCATION (City, town, or county) <b>Cecilton, Cecil Co.</b>	(State) <b>Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellowes</b>		ADDRESS <b>Wellington, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>MAR 16 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03033

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>CECIL</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WARWICK</i>		c. LENGTH OF STAY IN b. <i>14 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>MAIN ST.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WARWICK</i>	
3. NAME OF DECEASED (Type or print) <i>FRANCIS</i>		First <i>J.</i>	Middle <i>MULLEN</i>
4. DATE OF DEATH <i>MARCH 29 1959</i>	Month <i>MARCH</i>	Day <i>29</i>	Year <i>1959</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 14 1907</i>
9. AGE (In years lost birthday) <i>57</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>5</i>	11. IF UNDER 1 YEAR IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 1 YEAR IF UNDER 24 HRS Hours <i>0</i>
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED MECHANIC</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>AUTOMOTIVE</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>John F. MULLEN</i>	14. MOTHER'S MAIDEN NAME <i>CATHERINE Connor</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input checked="" type="checkbox"/> YES (If yes, give war or dates of service) <i>World War II</i>	
16. SOCIAL SECURITY NO. <i>221-05-308</i>	17. INFORMANT <i>MARY ANDERSON</i>	Address <i>816 Adams St. Wilm Del</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Massive myocardial Infarction</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		<i>Coronary occlusion</i>	
DUE TO (c)		<i>Benignisative Heart Disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary artery disease for past 2 years.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>Mar</i> Doy <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Cecilton, Md</i>
20f. (City or town) <i>Cecilton, Md</i>	(County) <i>Cecilton, Md</i>	(State) <i>Md</i>	
21. I certify that I attended the deceased from <i>Mar 24, 1958</i> , to <i>Mar 24, 1958</i> , that I last saw the deceased alive on <i>Mar 24, 1958</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wallace Obenshain</i>	ADDRESS (Street, city or town, state) <i>Cecilton, Md</i>		DATE SIGNED <i>24 Mar 59</i>
PHYSICIAN'S NAME (Type) <i>Wallace Obenshain</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		
22b. DATE THEREOF <i>MAR 20 1959</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>LAMBSON'S</i>	22d. LOCATION (City, town, or county) <i>GALENA</i>	(State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. H. Pfeifer Funeral Home</i>	ADDRESS <i>Span G. Lively Elkton Md</i>	24a. REC'D BY REGISTRAR DATE MAR 31 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03034

Reg. Dist. No.

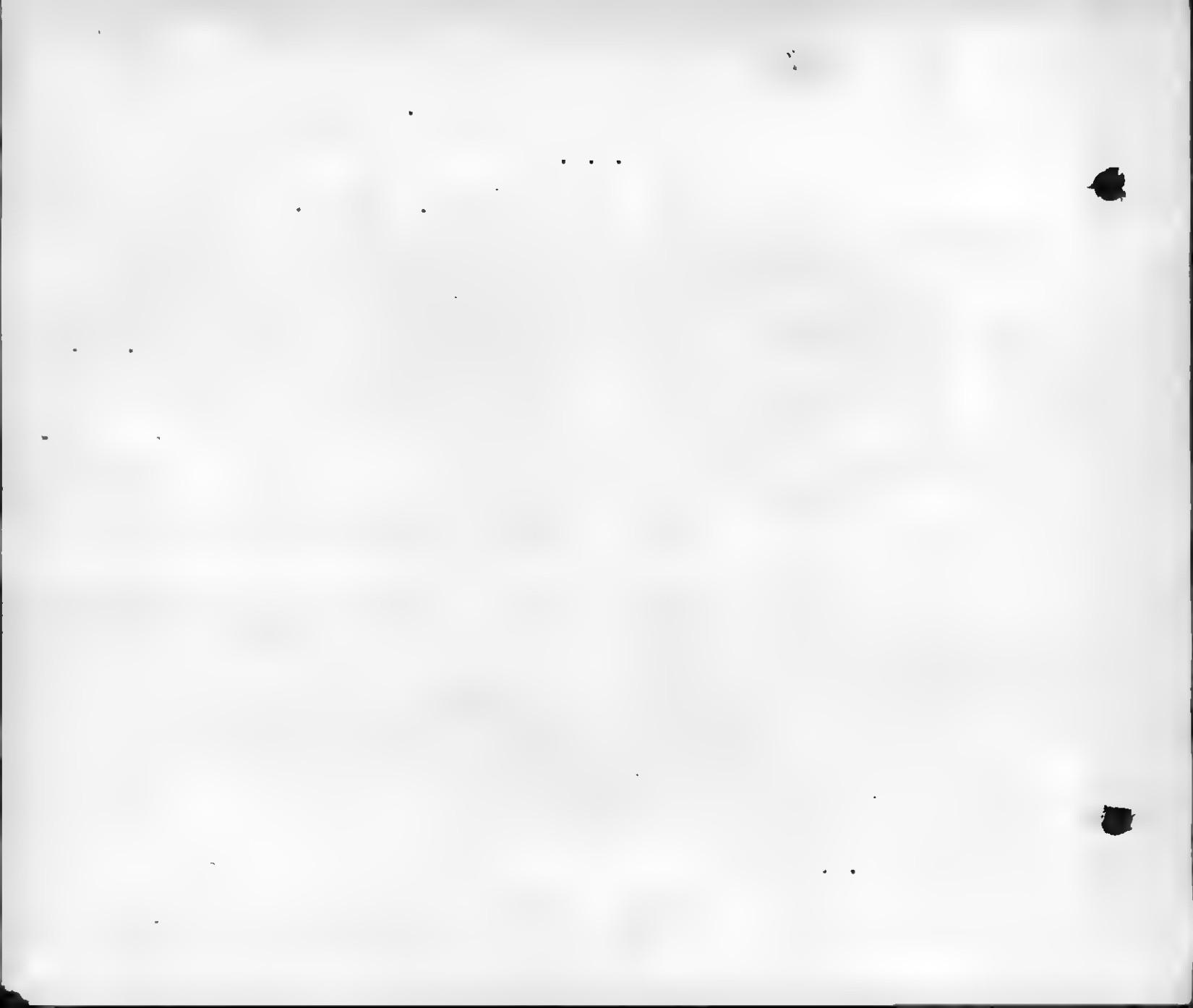
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM3. Page 5 may be retained by the funeral director.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. Give Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3021

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Md.	
		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b D.O.A.	
		d. STREET ADDRESS 172 E. Main St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Josephine		First	Middle
4. DATE OF DEATH Month 3		Month 12	Year 1959
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 3-19-1923	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY House Keeping	
11. BIRTHPLACE (State or foreign country) Kanasas City Missouri U.S.A.		12. CITIZEN OF WHAT COUNTRY? Address Elkton, Md.	
13. FATHER'S NAME Raymond Anaza		14. MOTHER'S MAIDEN NAME Louisa Fernandez	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Juan Pasada		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Massive Pulmonary Embolism INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (b) (c)		DUE TO Chronic Thrombo phlebitis of left Leb	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3-13-59	
EXAMINER'S NAME (Type)			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/59	
22c. NAME OF CEMETERY OR CREMATORIUM Gilpin Manor Memorial Park, Elkton, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph E. Hicks		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR Date MAR 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03035

Reg. Dist. No.

FOR STATE  
HEALTH DERT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by our files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3045

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived - If institutional, Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hacks Point, Earlvile R.D.</b>	
c. LENGTH OF STAY IN 3b <b>Life</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Earle Poore</b>		First	Middle
4. DATE OF DEATH	Month	Day	Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
<b>M</b>	<b>W</b>	<b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>	<b>6-4-1935</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lab. State Road</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Repairing roads</b>	
10c. BIRTHPLACE (State or foreign country) <b>Md.</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George M. Poore</b>		14. MOTHER'S MAIDEN NAME <b>Emma Craig</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Korean</b>		16. SOCIAL SECURITY NO. <b>214-34-3204</b> 17. INFORMANT <b>George M. Poore, Earlvile, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  X X Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.		DUE TO (b) Junction of p acietal and Fracture of right  frontal bone with laceration  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) DUE TO (c)	
Torn left ear Fracture left temperol Bone at  INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  Car ran off road and hit bank and threw him out of car	
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
How 2:30 a.m.	3 6 1959	While at work <input type="checkbox"/> of work <input type="checkbox"/>	20f. (City or town) <b>Route 213 Near Cecilton Cecilton R.D. Cecil Md.</b> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>  <b>A. C. Dodson</b>			
ACTUAL SIGNATURE	DATE SIGNED		
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-9-1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Cecilton Cemetery</b>	22d. LOCATION (City, town, or county) <b>Cecilton Cecil Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE  <b>Arthur W. Wellington Md.</b>	24a. REC'D BY REGISTRAR <b>Arthur S. Thomas</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	
DATE MAR 12 '59			

2.  $\sum_{n=1}^{\infty} \frac{1}{n^2}$

2

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03036

## CERTIFICATE OF DEATH

Reg. Dist. No.

3046

1. PLACE OF DEATH a. COUNTY  Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  North East		c. LENGTH OF STAY IN lb  40 years		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  North East			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS  Cecil Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)  Sarah		First	Middle	Lost	4. DATE OF DEATH  March	Month	Day	Year	
S. SEX  Female	6. COLOR OR RACE  White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH  October 4, 1867		9. AGE (In years less birthday) yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)  Delaware		12. CITIZEN OF WHAT COUNTRY?  USA			
13. FATHER'S NAME  George Gonc		14. MOTHER'S MAIDEN NAME  Susan Manning							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  No		16. SOCIAL SECURITY NO		17. INFORMANT  Mrs. J. Randolph Field		Address  York, Penn.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  44-201 DUE TO Coronary Occlusion						INTERVAL BETWEEN ONSET AND DEATH 1 min.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) DUE TO Essential Hypertension				5 yrs +			
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)  North East		(County) _____  North East	(State) _____  Md.
21. I certify that I attended the deceased from Nov., 1958, to 18 Nov., 1959, that I last saw the deceased alive on 11 Nov., 1958, and that death occurred at 5:15 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)  North East, Md.		DATE SIGNED  18 Nov. 59	
ACTUAL SIGNATURE  Klaus H. Heubner									
PHYSICIAN'S NAME (Type)  Klaus H. Heubner M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/59		22c. NAME OF CEMETERY OR CREMATORIUM North East First Cemetery		22d. LOCATION (City, town, or county) North East		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE  Joseph O'Gra		ADDRESS orth East, Inc.		24a. REC'D BY REGISTRAR DATE MAR 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-pass permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3022 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03037

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Cecil</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN lb <b>8 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton, R.D.</b>		d. STREET ADDRESS <b>Blue Bell Road</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>						e. IS RELATIVE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>James</b>		First	Middle <b>G</b>	Last <b>Rugh</b>	4. DATE OF DEATH <b>10-4-1881</b>	Month <b>3</b>	Day <b>23</b>	Year <b>19 59</b>
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-4-1881</b>	9. AGE (In years last b'day) <b>77</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Poultry</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Emmanuel Rugh</b>		14. MOTHER'S MAIDEN NAME <b>Clara Kuhn</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO		Address
17. INFORMANT <b>Mrs. James G. Rugh, Elkton, R.D., Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Shock Fracture of Temporal bone left both lower legs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>and left femur Laceration of scalp and face abrasions of face head and hands.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRINCIPAL <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Was hit by a car on Road</b>		20c. TIME OF INJURY Month, Day, Year <b>10-5-59</b>		20d. INJURY OCCURRED While work <input type="checkbox"/> Not while work <input checked="" type="checkbox"/> <b>3 22 59</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 545</b>	20f. (City or town) <b>Elkton</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. ACTUAL SIGNATURE <b>R.C. Dodson</b>		23. EXAMINER'S NAME (Type) <b>Ralph E. Hicks</b>		24. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3-23-59</b>
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-25-59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Cherry Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cherry Hill, Maryland</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph E. Hicks</b>		24. ADDRESS <b>Elkton, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 9 0 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knob</b>		
VS A15ME SM 2/57								



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G240 3-31-59 et

113038

3047

## CERTIFICATE OF DEATH

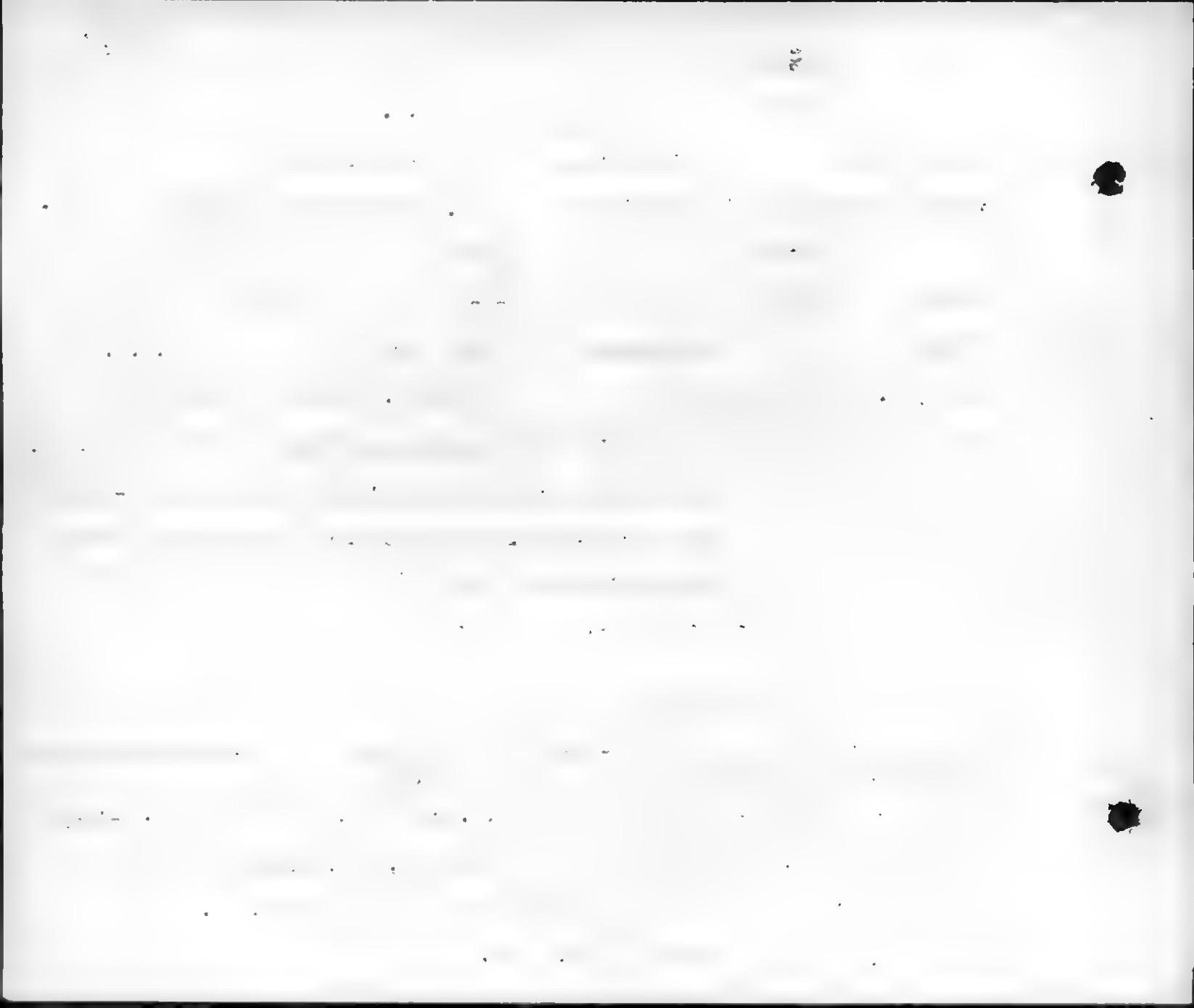
Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>D.C. ?</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN lb <b>5 yrs 24 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington ?</b>	
3. NAME OF DECEASED (Type or print) <b>Marietta</b>		First <b>(NMI)</b>	Middle <b>Stevens</b>
4. DATE OF DEATH <b>3 8 19 59</b>		Month	Day
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>9-4-73</b>		9. AGE (in years last birthday) <b>85</b> yrs	10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry S. Stevens (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Julia W. Gregory (Deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>Not Ascertainable</b>	
17. INFORMANT <b>Hospital Records VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia right middle &amp; lower lobes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15-18 days</b>	
DUE TO <b>Abcesses multiple right middle &amp; lower lobes</b>		unknown	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO <b>Broncho cutaneous sinus right</b>		unknown	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Arteriosclerosis, generalized, severe</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>While at work</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that / offended the deceased from <b>2-12-54</b> , 19, to <b>3-8</b> , 1959, and that death occurred at <b>2:00 AM</b> , from the causes and on the date stated above. and that death occurred at <b>2:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b>		DATE SIGNED <b>3-10-59</b>	
ACTUAL SIGNATURE <i>S. P. LACERVA</i>		V. A. Hospital, Perry Point, Md. 3-10-59	
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>3/11/1959</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Fort Myer, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington H. L.</i>		24a. REC'D BY REGISTRAR DATE <b>MAR 18 '59</b>	
ADDRESS <b>Havre de Grace, Md.</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. H.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3023 CERTIFICATE OF DEATH										Reg. Dist. No. 03003		
1. PLACE OF DEATH a. COUNTY <b>CECIL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON</b>			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Georgetown</b>			d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>UNION HOSPITAL</b>												
3. NAME OF DECEASED (Type or print) <b>BABY</b>		First	Middle	Last	4. DATE OF DEATH <b>TAYLOR</b>		Month	Day	Year			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 29, 1959</b>		9. AGE (In years last birthday) yrs. <b>MD.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min		
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <b>BABY</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>BABY</b>			11. BIRTHPLACE (State or foreign country) <b>MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>THOMAS E. TAYLOR</b>			14. MOTHER'S MAIDEN NAME <b>MARY E. RANSOM.</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>NONE</b>			16. SOCIAL SECURITY NO <b>THOMAS E. TAYLOR</b>			
17. INFORMANT <b>Fair Hill, Rd. 4, Elkton.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Prematurity</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
DUE TO <b>116 X</b>			Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>28 hours</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>MD.</b>			20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>MARCH 29, 1959</b> , to <b>MAR 29, 1959</b> , that I last saw the deceased alive on <b>March 29, 1959</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Henry V. Davis</b>										ADDRESS (Street, city or town, state) <b>CHESTERFIELD CITY MD.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			22b. DATE THEREOF <b>3/31/59</b>			22c. NAME OF CEMETERY OR CREMATORIUM <b>GALENA CEM.</b>			22d. LOCATION (City, town, or county) <b>GALENA</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows, Wellington Rd.</b>			ADDRESS <b>11111</b>			24a. REC'D BY REGISTRAR <b>APR 1 '59</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3048

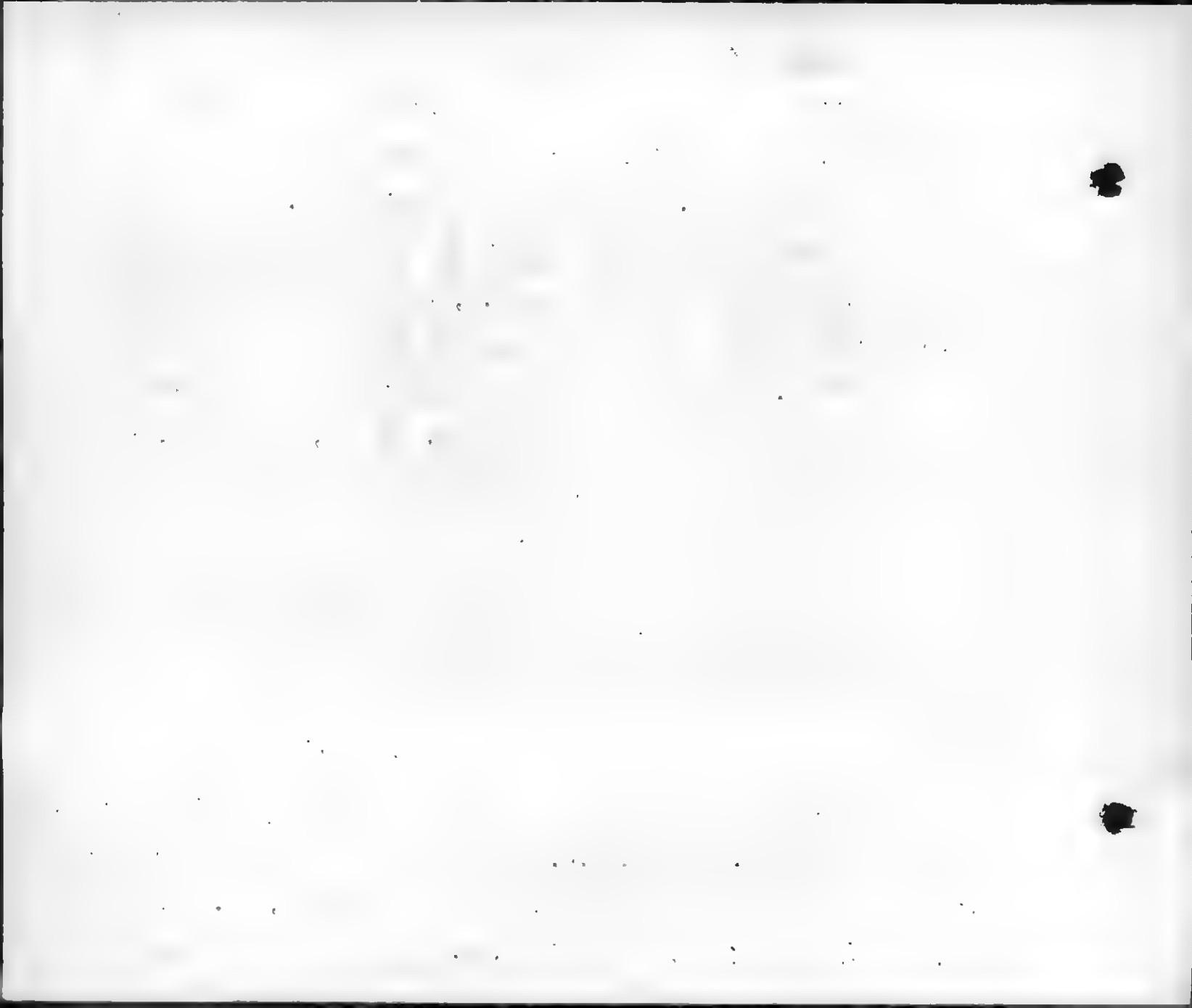
## CERTIFICATE OF DEATH

13039

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Aikin Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>	
f. STREET ADDRESS <b>Aikin Ave.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sallie</b>	First	Middle <b>Nickle</b>	Last <b>Taylor</b>
4. DATE OF DEATH <b>March 29 1959</b>	Month <b>March</b>	Day <b>29</b>	Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6, 1876</b>
9. AGE (In years from birthday) <b>82</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Frank H. Nickle</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Niblock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	INFORMANT <b>William L. Taylor, Perryville, Md</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>354X</b> DUE TO Condit.ans, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>82 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 26, 1959</b> , to <b>March 28, 1959</b> , that I last saw the deceased alive on <b>March 28, 1959</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clarence I. Benson</b>	ADDRESS (Street, city or town, state) <b>Hospital, Perryville, Md.</b> DATE SIGNED <b>March 31, 1959</b>		
PHYSICIAN'S NAME (Type) <b>Clarence I. Benson, M.D.</b>			
22a. BURIAL CREMATON. Burial	22b. DATE THEREOF <b>4-1-1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>West Nottingham</b>	22d. LOCATION (City, town, or county) <b>Colora, Md.</b> (State) <b>Rural</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Patterson, Son</b>	ADDRESS <b>Perryville, Md.</b>	24a. REC'D BY REGISTRAR DA <b>APR 1 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>



1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director.  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3049

## CERTIFICATE OF DEATH

03040  
96

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CECIL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>VIRGINIA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN lb <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>		First <b>H.</b>	Middle <b>WHITEHEAD</b>
4. DATE OF DEATH <b>March 1, 1959</b>		Last <b>WHITEHEAD</b>	Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 28, 1918</b>
9. AGE (In years lost birthday) <b>40 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Driver</b>	11. KIND OF BUSINESS OR INDUSTRY <b>Transit</b>	12. BIRTHPLACE (State or foreign country) <b>Virginia</b>
13. CITIZEN OF WHAT COUNTRY? <b>USA</b>	14. MOTHER'S MAIDEN NAME <b>Ida Brooks</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>MM-II</b>	INFORMANT <b>Hospital Records, VA Hospital, Perry Point, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia bilateral unresolved</b> INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the lungs bilateral with widespread metastases to the abdominal organs and bone</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. <b>VA</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>February 27, 1959</b> , to <b>March 1, 1959</b> , and that death occurred at <b>1:25 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>S. P. Lacerva</i>		ADDRESS (Street, city or town, state) <b>M.D. V.A. Hospital, Perry Point, Md.</b>	
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>		DATE SIGNED <b>3-2-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>3/3/1959</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Woodlawn</b>	22d. LOCATION (City, town, or county) (State) <b>Bluefield, West Virginia.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>PRIMINGTON &amp; SONS</i>	ADDRESS <b>Havre DeGrace, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>MAR 5 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Turner</i>

三

• 100 •

• 6 •

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3050

## CERTIFICATE OF DEATH

03041

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be retained** by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it may be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>N. Main St.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>	
3. NAME OF DECEASED (Type or print) <b>Lewis</b>		First <b>Lewis</b>	Middle <b>Henry</b>
4. DATE OF DEATH <b>3 20 1883</b>		Month <b>3</b>	Day <b>18</b>
		Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>3- 20- 1883</b>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) yrs. <b>75</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steam Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stationary Boiler.</b>	
10c. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Filmore</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-14-6047</b>	
		INFORMANT <b>Elma N. Wilson, N. Main St. Port Deposit,</b>	Address <b>Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>Adenosarcoma of the Throat 3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)  20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3/18</b> , 19 <b>59</b> , to <b>3/18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3/18</b> , 19 <b>59</b> , and that death occurred at <b>SA</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Neil R. Taylor</b>		ADDRESS (Street, city or town, state) <b>Rising Sun, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Neil R. Taylor, M.D.</b>		DATE SIGNED <b>3/19/59</b>	
22a. BURIAL, CREMATION; (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-21-1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>West Nottingham Cem.</b>	22d. LOCATION (City, town, or county) <b>Colora, Md. Rural</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kea, Patterson &amp; Sons</b>		ADDRESS <b>Perryville, Md.</b>	24a. REC'D BY REGISTRAR DATE MAR 23 '59
			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

